BlueCross BlueShield of Illinois

Illinois Employee Continuation Election Form

What is the Illinois Employee Continuation Privilege?

The Illinois employee continuation privilege protects a covered employee and dependents who lose group health insurance coverage due to employee's termination or reduction in hours.

Who Is Eligible for Illinois Employee Continuation Privilege?

Employee continuation may be triggered when a qualifying event occurs, including employee's job termination or reduction in hours, as follows:

- The employee and eligible dependents must have been continuously covered under the group plan for 3 months prior to the qualifying event.

Illinois employee continuation does not apply if:

- You were terminated for committing a work-related felony for which your employer was in no way responsible, and you have admitted to or been convicted of such felony;
- You were terminated for committing a work-related theft for which your employer was in no way responsible and you have admitted to or been convicted of such theft;
- You are covered by Medicare; or
- You are covered by any other insured or self-insured plan of group hospital, surgical or medical coverage.

How to Elect Illinois Employee Continuation Privilege

The completed Election Form must be returned to Blue Cross and Blue Shield of Illinois no later than 30 days after the receipt of the notification letter in the provided envelope, by certified mail, return receipt requested.

Explanation of Your Employee Continuation Privilege

Benefits under Illinois employee continuation privilege will continue unchanged. However, separate supplemental benefits such as dental may no longer be available under the continuation coverage.

Continuation resulting from an employee's termination or reduction of hours shall be offered for a maximum period of 12 months from when termination or reduction in hours began.

The premium for Illinois employee continuation for you, your spouse and dependent children may not exceed that of the group rate. You are responsible for paying the entire premium for the coverage, including the portion which was formerly paid by your employer.

Your employee continuation may terminate earlier than the maximum period if:

- You become eligible for Medicare;
- You are covered by any other insured or self-insured group medical, hospital or surgical plan;
- You fail to make timely premium payments for coverage; or
- Your employer terminates participation under the group policy and does not replace it with another group policy.

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☐ I hereby accept Illinois employee continuation coverage

or

☐ I hereby decline

Last Name		First Name		Middle Initial
Street Address		City	State	ZIP Code
Sex: ☐ Male ☐ Female	Coverage: (only select options available on the notification letter) ☐ Medical ☐ Dental	Date of Birth Mo/Day/Year	Social Security Number	Telephone Number
Group Number	Subscriber ID Number		Coverage Termination Date	
List Full Name of All Dependents To Be Covered				
Name of Dependent ☐ Male ☐ Female			Date of Birth Mo/Day/Year	Social Security Number
Complete **ONLY** if different than applicant Street Address		City	State	ZIP Code
Name of Dependent ☐ Male ☐ Female			Date of Birth Mo/Day/Year	Social Security Number
Complete **ONLY** if different than applicant Street Address		City	State	ZIP Code

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Name of Dependent ☐ Male ☐ Female			Date of Birth Mo/Day/Year	Social Security Number
Complete **ONLY** if different than applicant Street Address	City	State		ZIP Code
Name of Dependent ☐ Male ☐ Female			Date of Birth Mo/Day/Year	Social Security Number
Complete **ONLY** if different than applicant Street Address	City	State		ZIP Code

I understand that I am electing Illinois employee continuation of coverage. I certify I have read the continuation material furnished by BCBSIL and I am eligible for coverage. All information given on the Election Form is true and correct. I understand and agree: (1) any incorrect statements material to the eligibility for coverage shall invalidate the coverage, and (2) although I have elected coverage, only those coverage(s) for which I or my dependents are eligible will be available to me.

I understand that I have the sole obligation to pay the required premiums to the employer on the established due date. If I fail to pay such premiums within that time, the continued coverage may be cancelled as of the last day for which premiums were paid.

Please complete and return this form by certified mail (return receipt requested) in the provided envelope to BCBSIL:

Blue Cross and Blue Shield of Illinois
P.O. Box 660603
Dallas, TX 75266-0603

Your signature: _____ Date: _____